# Practice Improvement Protocol 1

## THE USE OF PSYCHOTROPIC MEDICATION IN CHILDREN AND ADOLESCENTS


**Developed by the**
**Arizona Department of Health Services**
**Division of Behavioral Health Services**

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## Issue

The safe and efficient use of psychotropic medications for the treatment of behavioral health conditions affecting children and adolescents.

## Purpose

To establish and maintain a process that promotes a model of clinical best practices regarding prescribing medications for children and adolescents.

## Target Population(s)

Children and adolescents enrolled in the RBHA/TRBHA systems that are prescribed psychotropic medications as an integral part of their treatment plans.

## Definitions

## Background

In order to provide for safety and effectiveness in medication prescription practices, clinician commitment to comprehensive treatment should be met by changes in delivery systems that enable the provision of quality care and the removal of limiting barriers. Psychiatric interventions require education about realistic expectations, sufficient time/resource to perform comprehensive psychiatric evaluations, well-defined diagnostic hypotheses, carefully defined target symptoms, ongoing assessments for response and adverse effects, consumer-oriented approaches to the physician-patient relationship, and the full use of available ADHS/DBHS Covered Services.

Medication is a collaborative process, and input from all stakeholders involved with the enrolled child should be included as needed to evaluate, maintain and improve medication regimes. Patients and their families should play an active role in all decisions relating to the management of their care. In order to be actively involved in making treatment decisions and providing adequate informed consent for treatment, patients and families have to be provided with complete and accurate information in a manner that they can understand. The prescriber therefore educates and advises rather than merely dictating treatment, and includes involved members as part of the treatment team.

The provision of psychotropic medications to children and adolescents must include informed consent, thorough assessment and evaluation, regular

monitoring of prescribed medication(s) by qualified professionals, coordination with others involved in the care and treatment of the member and close communication and input from the child/adolescent, parent(s) or guardians, and family members to support successful symptomatic and functional outcomes.

## Procedure

### Safe Prescribing Practices

T/RBHAs or their contracted providers should develop and implement the following mechanisms, protocols and documentation requirements:

Drug utilization reviews targeting potentially unsafe or clinically unsound prescribing practices:

1. Mechanisms (e.g., utilization data, prescribing patterns and peer reviews) to trigger immediate intervention and improvement actions for unsafe and/or ineffective prescribing practices. Findings derived from utilization data, prescribing patterns, peer reviews and other sources should be regularly disseminated to appropriate T/RBHA and subcontractor staff (e.g., committee meeting minutes, memorandums, direct communication via the medical director or designee);
2. Protocols to require that prescribing clinicians assess and monitor, as clinically indicated, the effects of medications on members, document target symptoms, document the medications' effectiveness, document adverse reactions and record follow up actions in the medical record.
3. Protocols to require that prescribing clinicians monitor the use of drugs known to have abuse potential, known to involve significant risks, or are known to be associated with significant undesirable side effects via the following:
    a. The absence or presence of movement disorders is assessed and documented before and on a regular basis after anti-psychotics are prescribed. The prescribing clinician's rationale for continuing or ending treatment is recorded in the member's medical record.
    b. Medications that have been shown to adversely affect hepatic, renal, endocrine, or cardiac function, other bodily functions or require serum level monitoring are assessed via appropriate laboratory studies.

c. Consultants knowledgeable and qualified in child and adolescent psychopharmacology are available to the prescribing clinician for second opinions regarding the use of medications that carry an unusually high risk of side effects, for which safety has not been reasonably established and/or for situations in which the member has not demonstrated the expected clinical response.

d. Health parameters such as weight, height, and blood pressure are collected as a part of a baseline assessment and, as appropriate, periodically monitored and recorded in the member's medical record.

4. Requirements for documentation in the member's medical record that the lowest effective therapeutic dose is being used for each medication and medications deemed to be ineffective are discontinued.
5. Mechanisms to require that adverse drug reactions and medication errors are reported immediately to the prescribing clinician and recorded in the member's medical record.
6. Requirements for documentation in the member's medical record that drug-drug interactions and food-drug interactions, as well as interactions with alternative medications (over-the-counter, herbal preparations, homeopathic remedies, etc.) have been reviewed by the prescriber and discussed with guardians.
7. Mechanisms to require that peer review, drug utilization review or other review processes be implemented when more than four psychotropic medications are used simultaneously or when more than one medication from the same class is prescribed.
8. Requirements for documentation in the member's medical record to reflect that adequate and appropriate follow up have occurred following the decision to discontinue a medication by the prescribing clinician.

**Informed Consent**

RBHAs, TRBHAs and providers should furnish the following information at a minimum, to parents/guardians through a combination of verbal exchanges and written handouts:

1. The member's condition or symptoms for which the medications are being prescribed

2. The intended outcomes, expected benefits of treatment, and potential side effects;
3. Alternatives to the proposed treatment;
4. The likelihood of success;
5. The right to withhold consent or withdraw consent;
6. The likely outcome and risks of not treating with medications and,
7. An acknowledgement that there may be unknown risks with medication use.

Written and verbal information should be offered in terminology understood by the guardian and member. If necessary to effectively communicate with the member and/or guardian, written and verbal information should be translated or provided by an interpreter.

Prior to prescribing psychotropic medications, written informed consent should be obtained from the legal guardian that clearly indicates that all required information referenced above has been reviewed. In situations where written consent cannot be immediately obtained, but withholding medication would create undue risk, verbal consent will suffice until written consent is received.

No medication changes or discontinuations should be implemented until reasonable attempts to reach guardians and elicit their input have been exhausted by the prescriber and/or designated staff. Reasonable attempts include, at a minimum, efforts to reach the guardian via telephone calls and the delivery of certified mail to the guardian's last known address. If clinical necessity warrants an immediate response, medication changes or discontinuations can be implemented, however, an attempt to reach the guardian should be made and recorded in the member's medical record.

Medication should be discontinued promptly if consent for treatment is withdrawn by the patient's guardian. If abrupt discontinuation could potentially result in adverse effects, the guardian should be so advised and medication withdrawn as quickly as clinically appropriate.

Parents/guardians should be informed of directions for administering, what signs/symptoms to monitor and to report to the prescriber, when it is appropriate or not appropriate to discontinue, steps to take in the event of

an emergency and how to reach the prescriber or designee to ask questions.

When clinically and developmentally appropriate, members should be involved in all discussions relating to medication use and informed consent.

**Coordination of Care with Family Members**

Child and family teams should be involved in all medication decisions. The patient's prescribing clinician should actively participate as a member of the child and family team.

**Coordination of Care with Inpatient Prescriber**

Prior to all referrals to inpatient facilities, or immediately upon becoming aware of an inpatient admission, the prescribing clinician or designee should contact the inpatient clinician to review the following information at a minimum:

The reason for admission;

1. The anticipated therapeutic goals of the inpatient stay and desired medication changes, or requests not to change if appropriate;
2. Current and past medication history and response to medication trials; and
3. Any other relevant data

The inpatient prescriber should inform the outpatient prescriber of all medication changes prior to, or at the time of discharge, and make available to the outpatient prescriber an up-to-date list of the member's discharge medications, dosages and clinical indications.

**Coordination of Care with Other Care Providers**

Each member's care will be coordinated with the primary care physician (PCP) as prescribed in applicable ADHS/DBHS Policy and Procedure 2.6 (Coordination Between T/RBHAs, AHCCCS Health Plans and Primary Care Providers).

The T/RBHAs/Providers must actively coordinate with the PCP, or other known prescriber, if there is evidence that a patient is receiving psychotropic medications for the same condition, or medications from the

same therapeutic class for different conditions simultaneously, from the prescribing behavioral health clinician and PCP, or other known prescriber.

As outlined in the Psychotropic Medication Initiative, members with diagnoses of mild depression, anxiety or attention deficit-hyperactivity disorder who are currently being treated by the T/RBHA or subcontracted prescriber may be referred back to the PCP for ongoing care following consultation with and acceptance by the person's PCP and health plan and with approval of the person. T/RBHAs should review the appropriateness of decisions to refer members to PCPs for ongoing care under the psychotropic medication initiative.

The prescribing clinician should actively coordinate care with behavioral health care providers and prescribing clinicians who are evaluating and treating members who are temporarily placed in detention and correctional facilities.

T/RBHAs/Providers should provide prescribing clinicians with adequate information from all available sources by outlining the expectations for ongoing information sharing between clinicians, therapists, case managers, PCPs and other behavioral health care providers and prescribing clinicians, and by outlining expectations for communication and information sharing between group home staff, foster families, CPS case workers, family members and any other parties involved in the care of the member

**Psychiatric Evaluations**

T/RBHAs should provide psychiatric evaluations for all members in a timely manner as prescribed in applicable ADHS/DBHS Policy and Procedure 1.9 (Timeliness of Service). Psychiatric evaluations are performed before medications are prescribed, and at regular intervals thereafter as clinically indicated. If a prescribing clinician prescribes a medication before a psychiatric evaluation can be completed, a detailed rationale for this decision should be documented in the member's medical record.

The psychiatric evaluation should be developed by considering all available sources of information (e.g., initial assessments, clinicians' progress notes, staffing notes, input from parents/guardians and teachers, direct assessment of the patient).

A comprehensive psychiatric evaluation of a child should include a synthesis of the following, at a minimum:

1. Biological, psychological, social, environmental and personal factors influencing diagnosis and treatment;
2. Birth and developmental history;
3. Estimated intelligence and cognitive functioning;
4. Social and Interpersonal skills;
5. Medical History and results of any physical examinations, laboratory, radiology, or other tests, if available;
6. Psychiatric history;
7. Education and special needs;
8. Safety in the community;
9. Character style;
10. Family circumstances and social history;
11. Substance use;
12. Legal issues;
13. Mental status examination, and;
14. Strengths